FORM A

CERTIFICATION OF HEALTH CARE PROVIDER
FOR EMPLOYEE'S SERIOUS HEALTH CONDITION

City of Helena

Section I – Employer Name and Contact Information:

City of Helena
316 North Park
Helena, MT 59623

Katherine Swindle, Risk & Benefits Manager
Telephone – (406)-447-8333
Fax – (406)-447-8444

Employee's job title: **Regular work schedule:**

Employee's essential job functions:

☐ **Job description is attached.**

Section II – Employee Information

Employee/Patient Information and Informed Consent for Disclosure of Health Care Information

Employee's Name: _____ Social Security Number: _____

Employee's Address: _____
City, State, Zip: _____ Telephone Number: _____

HIPAA-COMPLIANT AUTHORIZATION TO RELEASE INFORMATION:

By completing this document, I demonstrate my informed consent and authorization to allow the physician or practitioner identified on this form to release and disclose to **City of Helena Contact Representative, Katherine Swindle,** such health care records and information concerning my current medical condition as is necessary to support my request for a leave of absence and/or any additional benefits the employer may provide. This authorization is made per my request. This authorization shall be valid for two (2) years from the date shown below, unless revoked by me in writing at an earlier date. Although I understand that I may revoke this authorization in writing at any time, I also understand that any such revocation will not apply to any information that has already been released in reliance on this authorization, and that any revocation may have an adverse effect on the receipt of employer-provided benefits. I understand that my medical treatment is not conditioned upon me providing this authorization. I understand that if this authorization is for the release of psychotherapy notes I will complete a separate authorization for any other health information. I understand that information disclosed by the physician or practitioner to the employer may be subject to re-disclosure and not protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").
*IMPORTANT NOTE: The HIPAA Compliant Authorization to Release Information shown above is not required in order to be granted FMLA leave. You will not be refused FMLA leave if the HIPAA Compliant Authorization Release is not completed.

Employee Signature: _____ Date: _____

Alternatively, signature of Personal Representative and statement of authority to act on behalf of individual:

_____ Date: _____

Section III – Health Care Provider

Instructions to the Health Care Provider: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice/medical specialty: _____

Telephone: _____ Fax: _____

"The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services."

Part A: Medical Facts

1. Medical facts regarding Patient's Condition:

_____

_____

_____

Date condition commenced: _____
Probable duration of condition: _____

Last day worked: _____
Date expected to return to work: _____

Is (or was) patient incapacitated (unable to work, attend school, or perform regular daily activities)?
☐ Yes ☐ No

Please provide dates of incapacity:
_____

If patient remains incapacitated, how long is incapacitation expected to last?
_____

If the patient's condition is of a chronic nature, please describe likely frequency and duration of periods of incapacity: (Regiment of treatment to be prescribed. Indicate number of visits, general nature and duration of treatment, including referral to other provider of health services. Include schedule of visits or treatment if it is medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal schedule of hours per day or days per week.):

_____

_____

_____

_____

By another provider of health services:

_____

_____

Did employee's condition arise out of employment? ☐ Yes ☐ No

Is/was inpatient care of the employee required? If yes, dates: □ Yes □ No
Dates:
_____

Will the patient need to have treatment visits at least twice per year due to the condition? □ Yes □ No

Was medication, other than over-the-counter medication, prescribed? □ Yes □ No

2. Is the medical condition pregnancy? □ Yes □ No If so, expected delivery date:
_____

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

   If/was employee able to perform all of the functions of employee's regular position? (Answer after reviewing job description for essential functions of employee's regular position, or, if none provided, after discussing with employee.)
   □ Yes □ No If no, dates: _____

   If employee is currently unable to perform all of the functions of employee's regular position, is employee able to perform work of any kind? □ Yes □ No

   If yes, please describe in comments section below, including the dates such restrictions are expected to last:
   Comments:_____
   _____
   _____
   _____

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):_____
   _____
   _____
   _____

Part B – Amount of Leave Needed

1. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? □ No □ Yes

   If so, estimate the beginning and ending dates for the period of incapacity: _____
   _____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? □ No □ Yes

   If so, are the treatments or the reduced number of hours of work medically necessary? □ No □ Yes

   Estimate the treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:
   _____
   _____

Estimate the part-time or reduced work schedule the employee needs, if any:

_____hours(s) per day: _____days per week from _____ through _____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions?
   □ No □ Yes

   Is it medically necessary for the employee to be absent from work during the flare-ups? □ No □ Yes

   If so, explain:

   _____

   _____

   Based upon the patient's medical history and hour knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g. 1 episode every 3 months lasting 1-2 days):

   Frequency: _____times per _____week(s) _____months(s)

   Duration: _____hours or _____day(s) per episode

   Additional Information: Identify question number with your additional answer.

   _____

   _____

   _____

   _____

_____ _____

Signature of Health Care Provider **Date**